Health and Human Services

The Health and Human Services Agency (HHSA) oversees 12 departments and other state entities, such as boards, commissions, councils, and offices that provide health and social services to California's most vulnerable and at-risk residents. Services provided through programs such as Medi-Cal, California Work Opportunity and Responsibility to Kids (CalWORKs), and the regional centers touch the lives of millions of Californians. The Governor's Budget includes $83.5 billion ($27.1 billion General Fund and $56.4 billion other funds) for these programs. Figure HHS-01 displays expenditures for each major program area and Figure HHS-02 displays program caseload.

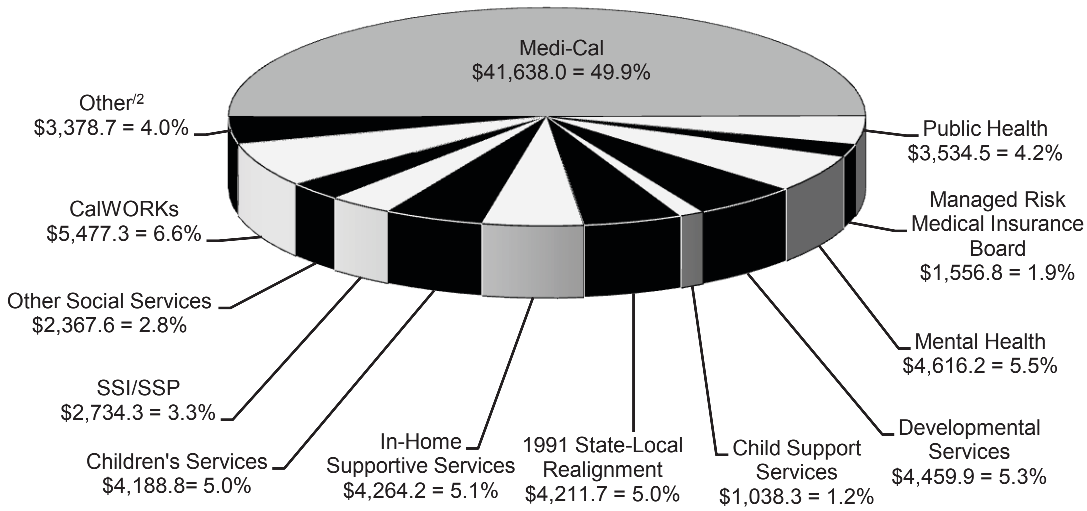
Department of Health Care Services

The Department of Health Care Services (DHCS) ensures that eligible persons and families receive comprehensive health services through public and private resources. By ensuring the appropriate and effective expenditure of public resources to serve those with the greatest health care needs, DHCS promotes an environment that enhances health and well-being.

Medi-Cal

Medi-Cal, California's Medicaid program, is administered by DHCS. Medi-Cal is a public health insurance program that provides comprehensive health care services at no or low cost for low-income individuals including families with children, seniors, persons with disabilities, foster care children, and pregnant women. The federal government dictates

Figure HHS-01
Health and Human Services Proposed 2011-12 Funding[/1]
All Funds
(Dollars in Millions)



/1 Totals $83,466.3 million for support, local assistance, and capital outlay. This figure includes reimbursements of $8,327.3 million and excludes enhanced federal funding and county funds that do not flow through the state budget.
/2 Includes the non-Medi-Cal portion of the Department of Health Care Services, Health and Human Services Agency, Department and Commission on Aging, Departments of Rehabilitation, Alcohol and Drug Programs, and Community Services and Development, Office of Statewide Health Planning and Development, State Independent Living Council, Emergency Medical Services Authority, California Children and Families Commission, State Council and Area Boards on Developmental Disabilities, California Medical Assistance Commission, Mental Health Services Oversight and Accountability Commission, and General Obligation bonds.

a mandatory set of basic services including, but not limited to, physician services, family nurse practitioner services, nursing facility services, hospital inpatient and outpatient services, laboratory and radiology services, family planning, and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits at additional state cost, such as outpatient drugs, adult day health care, and medical equipment.

Medi-Cal has an annual budget of $41.6 billion total funds ($13.0 billion General Fund, $24.1 billion federal funds, and $4.5 billion other funds) and Medi-Cal provides healthcare coverage to 7.7 million beneficiaries. Medi-Cal covers 19.7 percent of Californians and 23.9 percent of insured Californians. Medi-Cal funds about 46 percent of all births in California (see Figure HHS-03). California covers a relatively greater share of its population than other large states (13.2 percent in Texas and 17.9 percent in Ohio) or the national average of 15.7 percent.

Figure HHS-02

Major Health and Human Services Program Caseloads

	2010-11 Revised	2011-12 Estimate	Change
California Children's Services (CCS) [a]	47,050	48,520	1,470
(treatment of physical handicaps)			
Medi-Cal Enrollees	7,523,800	7,655,300	131,500
CalWORKs			
Average monthly individuals served	1,448,339	1,144,217	-304,122
Average monthly cases (families)	582,433	458,338	-124,095
Foster Care	53,586	47,628	-5,958
Adoption Assistance	85,281	88,431	3,150
SSI/SSP	1,266,078	1,276,413	10,335
(support for aged, blind, and disabled)			
In-Home Supportive Services	441,549	414,422	-27,127
Child Welfare Services [b]	119,188	115,304	-3,884
Non-Assistance CalFresh households	1,260,262	1,688,093	427,831
State Hospitals			
Mental health clients [c]	6,352	6,324	-28
Developmentally disabled clients [d]	1,979	1,783	-196
Community Developmentally Disabled Services			
Regional Centers	244,108	251,702	7,594
Vocational Rehabilitation	75,597	75,597	0
Alcohol and Drug Programs [e]	288,070	322,437	34,367
Healthy Families Program [f]			
Children	894,207	916,029	21,822

[a] Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS clients.

[b] Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one services area.

[c] Represents the year-end population. Includes population at Vacaville and Salinas Valley Psychiatric Programs.

[d] Represents average in-center population. Reflects the impact of Agnews Developmental Center closure.

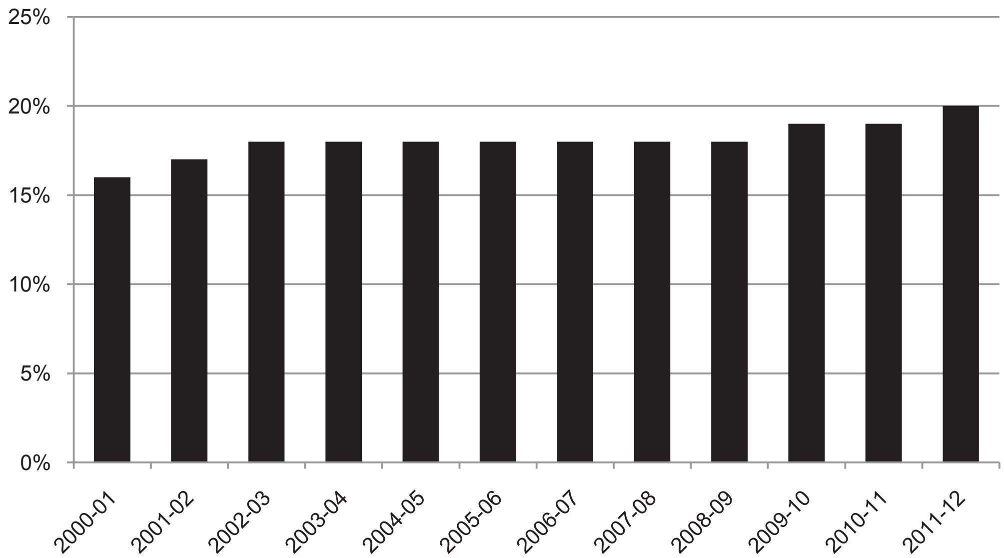
[e] Represents Drug Medi-Cal Clients.

[f] Represents the year-end population.

The state share of the program is funded primarily by the General Fund. The state and federal governments fund Medi-Cal in equal shares (50 percent each). Nationally, the federal government funds 57 percent of state Medicaid programs, and other large states such as Ohio (64 percent) and Texas (61 percent) receive a significantly greater share of federal funding while providing services to a lower percentage of state residents. The American Recovery and Reinvestment Act (federal stimulus) temporarily increased the federal government's share of funding from October 2008 through June 2011 to provide fiscal relief to states. These increased federal funds will provide an estimated $2.9 billion in General Fund relief in 2010-11. Absent program changes, Medi-Cal costs are expected to grow to $17.3 billion General Fund in 2011-12 (see Figure HHS-04).

Figure HHS-03

Average Monthly Medi-Cal Enrollees as a Percentage of California Population

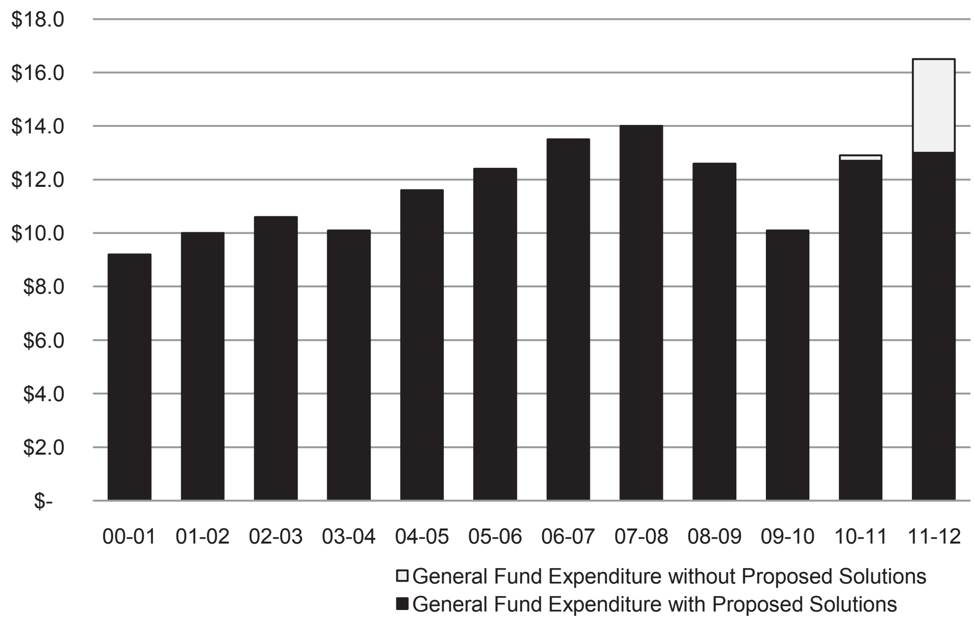


Medi-Cal is the second largest General Fund program, and represents approximately 15.4 percent of General Fund expenditures.

Medi-Cal costs generally grow between six and eight percent annually due to a combination of health care inflation and caseload growth. Over the last year, program expenditures grew by 5.9 percent after adjusting for the end of federal stimulus funding and other program factors that provide one-time General Fund relief in 2010-11. DHCS estimates that caseload will increase by 1.75 percent from 2010-11 to 2011-12 (from 7.52 million to 7.66 million – see Figure HHS-05). This is roughly double the 0.93-percent growth rate of the total California population over the same period (as estimated by the Department of Finance).

Medi-Cal costs are generally a function of the number of enrolled individuals, the level of benefits provided, and the rates paid to providers. Consequently, efforts to control program costs are typically focused in these areas. Federal health care reform prohibits reductions in eligibility standards. Adverse court rulings have prevented the state from implementing various provider payment reductions or from providing services only to beneficiaries with the greatest need. The Governor's Budget proposes significant reductions to this growing program while maintaining core services for

Figure HHS-04
Medi-Cal General Fund Expenditures
(dollars in billions)



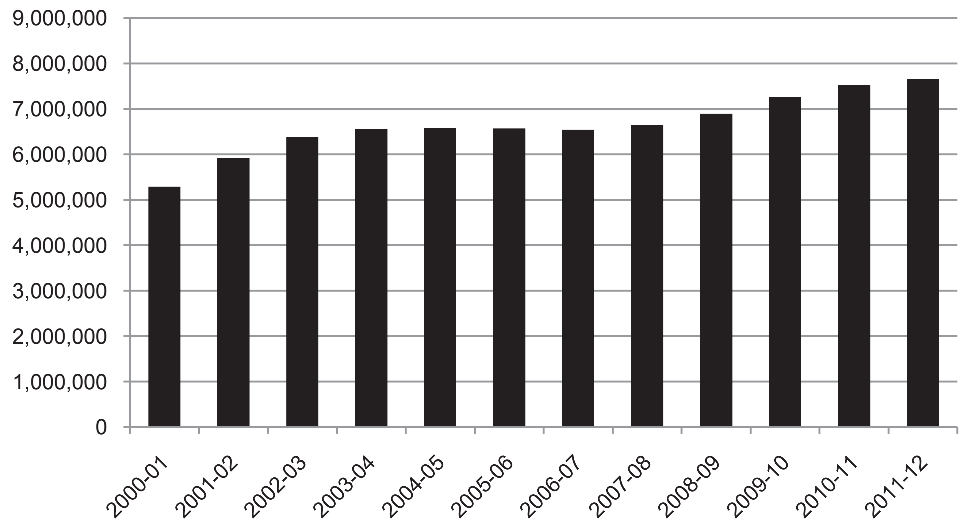
7.7 million beneficiaries. Each proposal assumes enacting state legislation by March 1, and some proposals may require federal approval prior to implementation. Further detail of proposed program reductions is provided below.

Limit Utilization of Services. California does not currently place strict limits on utilization of physician, clinic, outpatient, pharmacy, and other Medi-Cal services. Prior approval is required to obtain more than six prescriptions per month, but there is no benefit limit. Approval is also required for inpatient services, but most approvals for inpatient services are granted after the service is provided (the program does not pay for disallowed inpatient services). In contrast, Texas and Illinois have a hard limit of three prescriptions per month. Other states also limit access to inpatient and outpatient services.

This proposal establishes utilization controls at a level that ensures that 90 percent of beneficiaries who utilize a particular service remain unaffected, which is consistent with federal Medicaid law. Specifically, it sets a maximum annual benefit dollar cap

Figure HHS-05

Average Monthly Medi-Cal Caseload



on hearing aids ($1,510), durable medical equipment ($1,604), incontinence supplies ($1,659), urological supplies ($6,435), and wound care ($391), limits prescriptions (except life-saving drugs) to six per month, and limits the number of doctor visits to ten per year. The limits on medical supplies and equipment save an estimated $9.8 million in 2011-12 and affect approximately 20,000 beneficiaries. The limit on prescription drugs saves an estimated $11.1 million in 2011-12. The limit on physician visits saves an estimated $196.5 million in 2011-12 and reduces the number of physician visits funded by Medi-Cal from approximately 3.3 million to 2.0 million annually. These changes would take effect no later than October 1, 2011 based on the time needed to obtain federal approvals and provide necessary beneficiary and provider notification.

Require Beneficiaries to Share in the Cost of Services. Currently, co-payments in Medi-Cal are voluntary. State law permits co-payments of $1 for most doctor, clinic, and pharmacy services and $5 for emergency room visits. Providers collect little if any, co-payments and are not required to remit the payments to the state. Other states also have voluntary co-payments, which are higher than those established in California. For example, New Mexico charges $5 for most visits and Montana charges $4. Tennessee, Virginia, Montana, and Alaska charge $100 per day with a $200 maximum for hospital admissions. South Dakota charges five percent of costs up to $50 for emergency room visits. Through a state law change and a federal waiver, co-payments would become mandatory.

The federal government currently limits cost sharing for non-exempt populations to relatively nominal amounts and aggregate caps on co-payments not exceeding 5 percent of family income. Federal law (Deficit Reduction Act) allows providers to deny service if the beneficiary does not provide required co-payments, as long as they give a referral to a county indigent health program. Mandatory co-payments will achieve savings by reducing the amount the state pays for services (the current rate less the co-payment amount) and decreasing utilization. Specifically, this proposal includes a $5 co-payment on physician, clinic, dental, and pharmacy services ($3 on lower-cost preferred drugs) for savings of $294.4 million in 2011-12. There would also be a $50 co-payment on emergency room services (saving $111.5 million in 2011-12) and a $100/day and $200 maximum co-payment for hospital stays (saving $151.2 million in 2011-12). All beneficiaries who utilize these services would be subject to the co-payments. Except for the dental co-payment (May 1, 2011), these changes would take effect October 1, 2011, based on the time needed to obtain federal approvals and provide necessary beneficiary and provider notification.

Eliminate Adult Day Health Care and Other Benefits. Federal Medicaid rules require states to provide certain benefits as part of its Medicaid program. States also have the discretion to provide additional benefits that are eligible for federal matching dollars. The 2009-10 Budget included the elimination of some optional benefits including dental, podiatry, chiropractic, and other services. Prior to the elimination of these benefits, California was among the most generous states when considering the number of optional benefits offered. According to DHCS, the benefits now offered are similar to what other states typically offer. California is one of few states that currently operates an Adult Day Health Care program.

Recently, the courts have ruled against efforts to scale back optional benefits, such as Adult Day Health Care, yet have upheld elimination of these benefits, such as dental services. Consistent with prior court rulings, this proposal would eliminate over-the-counter cough and cold medications and nutritional supplements as Medi-Cal benefits (saving $556,000 in 2010-11 and $16.6 million in 2011-12). This proposal would also eliminate the optional Adult Day Health Care program for savings of $1.5 million in 2010-11 and $176.6 million in 2011-12. Approximately 27,000 beneficiaries use Adult Day Health Care services each month in about 330 centers statewide.

Reduce Medi-Cal Provider Payments by 10-Percent. The Budget proposes to reduce provider payments by 10 percent for physicians, pharmacy, clinics, medical transportation, home health, Adult Day Health Care, certain hospitals, and nursing facilities. Consistent with the 10-percent reductions proposed for other providers, this proposal would also reduce rates for long-term care facilities, including nursing home by 10 percent. This proposal will require federal approval of a state plan amendment. This proposal would save an estimated $9.5 million in 2010-11 and $709.4 million in 2011-12.

State and federal court rulings have recently prevented the state from implementing statutorily mandated rate freezes and reductions. Courts have enjoined provider payment reductions or rate for a wide variety of provider types including physicians, pharmacy, dental, Adult Day Health Care, clinics, and certain long-term care providers. Judicial concerns have primarily been that reductions could restrict access to care, and that rate studies have not been performed before enacting and implementing rate reductions.

The state has appealed to the U.S. Supreme Court to overturn adverse appellate court rulings that have blocked provider payment reductions of up to 10 percent. It is anticipated that the U.S. Supreme Court will decide whether to hear the cases by mid-January 2011 and would rule by July 1, 2011. This proposal assumes the state prevails in pending rate litigation.

Use Proposition 10 Reserves to Fund Health Services for Young Children. The California Children and Families Program (known as the First 5 program) was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the state Children and Families Commission (Commission), which provide early development programs for children through age five. Funding is provided by a cigarette tax (50 cents per pack), of which, after accounting for specified adjustments, 80 percent is allocated to the county commissions and 20 percent is allocated to the Commission. Unspent funds are carried over for use in subsequent fiscal years. Over time, both the state and local fund balances have grown. As of June 30, 2009, county commissions held more than $2 billion in reserves. The Governor's Budget proposes to use $1 billion in Proposition 10 funds to fund Medi-Cal services for children through age five. This will allow for the continued funding of core programs providing early childhood health services. Subject to voter approval, this proposal would take effect July 1, 2011.

Extend the Existing Hospital Fee. Existing law provides for a hospital fee through December 31, 2010. The Governor's Budget proposes to extend the fee through June 31, 2011, which will save $160 million in Medi-Cal. Fee revenue is used to leverage federal funding to provide supplemental payments to hospitals for the provision of Medi-Cal services and to offset General Fund costs to a lesser degree.

The significant General Fund workload adjustments are as follows:

- Expiration of Federal Stimulus Funds — An increase of $2.9 billion due to the end of federal stimulus funding. The federal government assumed a greater share of program costs during the stimulus period of October 2008 through June 2011.
- Expiration of Hospital Fee Offsets — An increase of $1.1 billion General Fund in 2011-12 and a decrease of $4.0 billion special funds resulting from the sunset of the hospital fee program June 2011, after the six-month extension discussed above. The $1.1 billion includes: (1) $560 million from all seven quarters of hospital fee payments being made during 2010-11 (the fee provides $80 million per quarter to offset Medi-Cal costs for children's services), (2) $420 million in funds originally intended for public hospitals that have instead been redirected to the state (public hospitals are held harmless by receiving additional Medi-Cal waiver funds), and (3) $160 million for the two-quarter extension. Hospital fee revenues will be used to leverage federal dollars to provide substantial supplemental payments to hospitals for Medi-Cal services. Including the extension period, up to $1.1 billion of hospital fee revenues are also available to offset General Fund costs in Medi-Cal.
- Medi-Cal Base Benefit Costs — An increase of $306.3 million (including a $137.7 million increase in Fee-For-Service costs, an $87.0 million increase for managed care, and an $81.5 million increase for Medicare payments and other base adjustments).

The significant General Fund policy issue adjustments are as follows:

- Managed Care Rate Increase — An increase of $160 million in 2011-12. This request will be adjusted in the spring when actuarially approved managed care rate assessments will be completed. Federal law requires DHCS to set managed care rates at a level that is actuarially sound. The estimated increase is 3.9-percent, which is consistent with the increase provided in the current year.

- Health Care Reform Implementation—An increase of $2.1 million ($949,000 General Fund) and 17 two-year limited-term positions to implement provisions of federal health care reform.

A summary of the significant General Fund budget solutions follows:

- Limit Utilization of Services—A decrease of $217.4 million in 2011-12.
- Require Beneficiaries to Share in the Cost of Services—A decrease of $180,000 in 2010-11 and $557.1 million in 2011-12.
- Eliminate Adult Day Health Care and Other Benefits—A decrease of $2.1 million in 2010-11 and $193.2 million in 2011-12.
- Reduce Medi-Cal Rates by 10 Percent—A decrease of $9.5 million in 2010-11 and $709.4 million in 2011-12.
- Redirect Proposition 10 Reserves—A decrease of $1 billion in 2011-12.
- Extend the Existing Hospital Fee—A decrease of $160 million in 2010-11.

Managed Risk Medical Insurance Board

The Managed Risk Medical Insurance Board (the Board) administers five programs that provide health coverage through commercial health plans, local initiatives and county organized health systems to certain persons who do not have health insurance. The five programs include:

- The Access for Infants and Mothers Program, which provides comprehensive health care to pregnant women and educates women about the dangers of tobacco use.
- The Healthy Families Program, which provides comprehensive health, dental, and vision benefits through participating health plans for children who are not eligible for Medi-Cal.
- The County Health Initiative Matching Fund Program, which provides comprehensive benefits similar to the Healthy Families Program, but through county-sponsored insurance programs.
- The Major Risk Medical Insurance Program, a state-funded program which provides health coverage to residents of the state who are unable to secure adequate

coverage for themselves and their dependents because insurers consider them to be ''medically uninsurable''—at high risk of needing costly care.

- The Pre-Existing Conditions Insurance Plan Program (PCIP), a federally funded health coverage program which provides health coverage to medically uninsurable individuals who live in California.

The Governor's Budget includes $1.6 billion ($267.5 million General Fund) for the Board, an increase of $136.7 million General Fund from the revised 2010-11 budget and $128.3 million General Fund from the Budget Act of 2010.

Healthy Families Program

The Healthy Families Program, the state's federal State Children's Health Insurance Program (SCHIP), provides insurance for approximately 900,000 children up to age 19 in families with incomes up to 250 percent of the federal poverty level that are not eligible for Medi-Cal coverage. Coverage includes comprehensive health, dental, and vision benefits through participating health plans. Families pay a monthly premium and the program subsidizes the remaining cost of coverage. Premiums account for 16 percent of total program costs. Costs are funded through a combination of state and federal SCHIP funds. State funds are matched two to one.

State law requires the Managed Risk Medical Insurance Board to operate Healthy Families within its appropriation. Healthy Families is not an entitlement, and the program has previously used a waiting list, cost sharing, alternative fund sources (such as the Managed Care Organization Tax, which provided $114.5 million in 2010-11), or service reductions to remain within its appropriation. Federal health care reform recently instituted a new maintenance-of-effort (MOE) requirement on Healthy Families that prohibits reductions in eligibility standards. Failing to comply places all federal SCHIP funds (approximately $750 million) and Medicaid funds ($26 billion) at risk. States still have some flexibility to increase cost sharing, limit benefits, or use alternative funding for the state match. The following proposed solutions include all of these cost-containment strategies.

Eliminate the Vision Benefit. Healthy Families provides vision services through its health plan (testing, eye refractions to determine the need for corrective lenses, and care for injuries) and also through separate vision coverage (including eyeglasses and other specialized services).

This proposal would eliminate the separate vision coverage for all children participating in Healthy Families resulting in General Fund savings of approximately $11 million. Vision services through health plans would remain (vision testing, eye refractions to determine need for corrective lenses, and care for eye injuries, etc.). This proposal would take effect June 1, 2011, after appropriate provider and beneficiary notification.

Increase Premiums. Monthly premiums for Healthy Families range from $7 to $72, depending on income and family size. Premiums were increased once in 2005 and twice in 2009. Fourteen other states also increased premiums in 2009, including Florida, New York, Pennsylvania, Wisconsin, Washington, and Arizona (which doubled premiums from $17.50 to $35 per child in families at 200 percent of poverty). States currently with the highest premiums at 200 percent of poverty are Arizona at $35 per child, Rhode Island at $30, Minnesota at $28, and Georgia at $20. Healthy Families eligibility levels in California are more generous than many other states as 18 other states do not cover the population from 200 to 250 percent of poverty.

The Budget proposes to increase premiums for families with incomes at or above 150 percent of poverty (approximately 565,000 children) for General Fund savings of approximately $22 million. Premiums would increase for the income group from 150 to 200 percent of poverty by $14 per child (from $16 to $30) and increase the maximum limit for a family with three or more children by $42 for a family maximum of $90. For families with incomes from 200 to 250 percent of poverty, premiums would increase by $18 per child (from $24 to $42) and the maximum limit for a family with three or more children would increase by $54 to $126. No increase is proposed for families with incomes under 150 percent of poverty. The proposed premium levels are consistent with premium levels in effect in other states and proposed changes would take effect June 1, 2011, after appropriate provider and beneficiary notification.

Increase Co-payments. Healthy Families has co-payments that cover doctors' visits ($10), prescriptions ($15 for brand-name drugs, and $10 for generic drugs), and emergency room visits ($15). Beneficiaries are not denied service for inability to pay. An annual co-payment maximum of $250 per family also exists. In November 2009, co-payments were increased by $5 for doctor visits and generic drugs, and by $10 for brand-name drugs and emergency room visits. There is no current co-payment for inpatient hospital stays.

This proposal would increase co-payments for emergency room visits from $15 to $50 and inpatient stays from $0 to $100 day/$200 maximum, to conform to a similar Medi-Cal cost-containment proposal. This proposal would take effect October 1, 2011, after appropriate provider and beneficiary notification. This proposal will result in savings of $5.5 million.

Continue Collecting Revenues from Taxes Assessed on Managed Care Plans. California currently taxes managed care organizations, and uses these revenues to draw down federal funds, to fund rate increases in Medi-Cal, and to provide health coverage in Healthy Families. Health plans benefit by receiving higher rates than would otherwise result. This tax expires on June 30, 2011.

The budget proposes to make this tax permanent and to use the revenues for rate increases in Medi-Cal and to fund health coverage in Healthy Families, for savings of $97.2 million.

The significant General Fund workload adjustment is:

- A decrease of $24.5 million in 2011-12 resulting from a decrease in enrollment.

The significant Non-General Fund workload adjustment is:

- Alternative Funds—An increase of $258.2 million in 2011-12 as a result of the expiration of managed care organization (MCO) tax funds and Proposition 10 funds that were previously available to offset General Fund expenditures in the program. The statutory authority for the MCO tax sunsets June 30, 2011.

A summary of the significant General Fund solutions follows:

- Eliminate the Vision Benefit—A decrease of $0.9 million in 2010-11 and $11.3 million in 2011-12.
- Increase Premiums—A decrease of $1.9 million in 2010-11 and $22.2 million in 2011-12.
- Increase Copayments—A decrease of $5.5 million in 2011-12.
- Continue Collecting Revenues from Taxes Assessed on Managed Care Plans —A decrease of $97.2 million in 2011-12.

Department of Public Health

The Department of Public Health (DPH) is charged with protecting and promoting the health status of Californians through programs and policies that use population-wide interventions. The DPH programs work to prevent chronic diseases, such as cancer and cardiovascular disease, environmental and occupational diseases and communicable diseases, such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). The DPH licenses and certifies health care facilities; protects the public from consuming unsafe drinking water; manages and regulates the safety of food, drugs, medical devices and radiation sources; and, operates public health laboratories. The DPH also operates family health programs, such as the Women, Infants and Children program, maternal, child and adolescent health and genetic disease testing and related services. The DPH is responsible for managing the state's public health information, including vital statistics and public health emergency preparedness.

The DPH is funded with a combination of General Fund, federal funds, and various special funds. Funding for 2010-11 is $3.4 billion ($204.8 million General Fund), and proposed funding for 2011-12 is currently $3.5 billion ($314.9 million General Fund).

Increasing Client Share of Costs for the AIDS Drug Assistance Program (ADAP)

ADAP was established in 1987 to help ensure that HIV-positive uninsured and underinsured individuals have access to medication. Currently, over 180 drugs are available through ADAP, and there are over 4,000 pharmacies statewide where clients can access these drugs. Additionally, there are more than 200 enrollment sites throughout California. ADAP is funded with a combination of General Fund, federal funds, and drug manufacturer rebate funds. The revised 2010-11 budget is $478.5 million ($71.4 million General Fund), and proposed funding for 2011-12 is $518.5 million ($163.8 million General Fund). State and federal law requires that ADAP funds be used as the payer of last resort.

Approximately 38,000 individuals received ADAP services in 2009-10, and it is estimated that 39,500 individuals will receive services in 2010-11. To qualify for ADAP, individuals must be California residents 18 years of age or older, have a Federal Adjusted Gross Income that does not exceed $50,000, and lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal. Individuals with an annual Federal Adjusted Gross Income below 400 percent of the federal poverty level receive ADAP drugs at no cost. An average annual client share of cost of $561 is required for anyone whose annual adjusted gross income is between 400 percent of the federal poverty level (currently $43,320) and $50,000.

The Governor's Budget would increase client share of cost in ADAP to the maximum percentages allowable under federal law for specified ADAP clients. It would limit cost-sharing for ADAP clients with private insurance or Medicare Part D to a lower cost-sharing percentage. This would result in net General Fund savings of $16.8 million.

A summary of the significant General Fund workload adjustments follows:

- Safety Net Care Pool Funding for ADAP—A one-time decrease of $76.3 million General Fund in 2010-11 as a result of additional federal resources available through the Safety Net Care Pool.
- Every Woman Counts Program—A decrease of $10.6 million in 2010-11, and a reappropriation of these funds in 2011-12, as a result of a five-month delay in implementing the program reforms adopted in the 2010 Budget Act. An increase of $11.7 million ($7.7 million General Fund) in 2011-12 as a result of increased caseload projections for the program.
- ADAP Program—An increase of $52.1 million ($22.1 million General Fund) in 2010-11 and $108.9 million ($55.1 million General Fund) in 2011-12 as a result of a projected increase in prescription drug costs and caseload for the program.

Emergency Medical Services Authority

The Emergency Medical Services Authority (EMSA) is responsible for providing statewide coordination of emergency medical services (EMS); regulating the education, training and certification of EMS personnel; developing guidelines for local emergency medical services; and coordinating the state's medical response to any disaster. The EMSA provides overall coordination for the 7 multi-county regions and 25 single-county EMS agencies that provide emergency medical services in California's 58 counties.

The EMSA is funded with a combination of General Fund, federal funds, and reimbursements. Funding for 2010-11 is $28.6 million ($8.4 million General Fund), and proposed funding for 2011-12 is currently $27.4 million ($6.8 million General Fund).

Re-thinking Health Care Surge Capacity

In 2006-07, EMSA and DPH received a total of $166 million to purchase mobile field hospitals and a stockpile of medical supplies, antivirals, and respirators to be used in the event of a disaster. The $5.8 million California spends annually to maintain these supplies is not included in this Budget. The supplies have been used minimally since their purchase. The mobile field hospitals have never been deployed. Given minimal use of these assets, ongoing costs, and California's fiscal situation, the state needs to re-think how it supports health care surge capacity.

Department of Aging

The California Department of Aging (CDA) contracts with the network of Area Agencies on Aging, that directly manage an array of federal and state-funded services that help older adults find employment; support older and disabled individuals to live as independently as possible; promote healthy aging and community involvement; and assist family members in their care giving role. CDA also contracts directly with agencies that operate the Multipurpose Senior Services Program through the Medi-Cal home and community-based waiver for the elderly, and certifies Adult Day Health Care centers for the Medi-Cal program.

The Governor's Budget includes $182.2 million ($15.1 million General Fund) for the CDA, a decrease of $17.7 million General Fund from the revised 2010-11 budget and $18.0 million General Fund from the Budget Act of 2010.

Eliminate the MSSP optional benefit. The local Multipurpose Senior Service Program (MSSP) sites provide case management services for elderly clients who qualify for placement in a nursing facility but who wish to remain in the community. The program has 41 sites statewide and serves approximately 11,789 clients per month. Clients must be 65 years of age or older, currently eligible for Medi-Cal, be appropriate for case management services, and certified or certifiable for placement in a nursing facility. In addition to case management services, MSSP funds are also used to provide adult day care, housing assistance, chore and personal care assistance, protective supervision, respite, transportation, meal services, social services, and communications services. The MSSP program assists seniors in obtaining access to these services elsewhere in the community or through state programs first, and uses MSSP funds as a last resort for any potential gaps in needed care.

This proposal would eliminate these services for a savings of $19.9 million General Fund in 2011-12.

Department of Developmental Services

The Department of Developmental Services (DDS) serves approximately 244,000 individuals with developmental disabilities in the community and 1,979 individuals in state-operated facilities. Proposed funding for 2011-12 is $4.5 billion ($2.4 billion General Fund). Services are provided through the developmental centers and community care facilities and the regional center system. Prior to 1969, services for individuals with developmental disabilities were primarily limited to those provided in state-operated institutions. The Lanterman Developmental Disabilities Services Act established a statewide network of regional centers and related services to allow consumers to live independent and productive lives in the community.

During the development of the 2009-10 and 2010-11 Governor's Budgets, the DDS, with input from a workgroup comprised of regional centers, service provider representatives, advocacy groups, consumers and family members, and legislative staff, developed proposals to reduce or restrict General Fund growth in the department's budget. In 2009-10, the DDS developed proposals that resulted in approximately $334 million in General Fund savings and an additional $200 million in 2010-11. Savings proposals impacted both the developmental center and regional center budgets, and included a variety of strategies such as restructuring, reducing or eliminating various services, restricting eligibility for certain services, and maximizing other available funding sources, primarily federal funds. In addition to these proposals, payments for community services were reduced by 3 percent in 2009-10 and 4.25 percent in 2010-11.

The DDS budget would have grown in 2011-12 by $289.9 million because of increased caseload, utilization and the expiration of the 4.25-percent payment reduction. In addition, the General Fund need increases by $195.6 million due to the end of the federal stimulus funding and program growth. Given the continued pressure on the General Fund, the Governor's Budget proposes to reduce an additional $750 million in General Fund system-wide through additional federal revenues, increased accountability, expenditure reductions and cost-containment measures, with the intent of maintaining the Lanterman entitlement to community-based services for individuals to avoid more costly institutionalization.

Developmental Centers

Developmental centers are licensed and certified 24-hour, direct-care facilities that provide services to persons with developmental disabilities. The DDS currently operates four developmental centers, and one community facility. The Governor's Budget includes $618.1 million ($324 million General Fund) for developmental centers.

Savings Proposals. As part of the $750 million savings proposal, the DDS will pursue additional federal funds for treatment services provided to individuals residing in the secure facility at Porterville Developmental Center. It is anticipated this will result in General Fund savings of $10 million in 2011-12. The DDS will also consider other proposals to achieve General Fund savings.

Additionally, in April 2010, the Legislature was notified of the DDS' intent to initiate the closure of the Lanterman Developmental Center. Lanterman, located in Pomona, currently serves just under 350 consumers and employs approximately 1,150 staff. It is anticipated the closure process will take at least two years. Closure will only occur when necessary services and supports are in place and each resident has transitioned to alternative living arrangements.

The significant General Fund workload adjustments are as follows:

- Workforce Cap Adjustment—A decrease of $6.7 million in 2010-11 and a decrease of $13.3 million in 2011-12.
- Personnel Costs—A decrease of $11.2 million in 2010-11 as a result of negotiated contract savings and the continuation of furloughs for employees without contracts.
- Expiration of Federal Stimulus Funds—An increase of $27 million due to the end of federal stimulus funding. The federal government assumed a greater share of program costs during the stimulus period of October 2008 through June 2011.

Regional Centers

The 21 regional centers, located throughout California, are non-profit corporations contracted by DDS to purchase and coordinate services mandated under the Lanterman Act for persons with developmental disabilities. Services include outreach, intake, diagnosis and assessment of needs, coordination of services, resource development, residential placement and monitoring, case management, quality assurance and individual program planning assistance. The Governor's Budget includes $3.8 billion ($2 billion General Fund) for regional center operations and services.

Savings Proposals. As part of the $750 million savings proposal, the DDS will:

Continue Temporary Regional Center and Service Provider Payment Reductions. The 2010 Budget Act contains a 4.25-percent reduction to regional center and service provider payments. These payment reductions are scheduled to sunset on June 30, 2011. The Governor's Budget proposes to extend both payment reductions for another year resulting in General Fund savings of $91.5 million in 2011-12.

Continue Proposition 10 Funding. The regional center budget includes $50 million in reimbursement funding in 2010-11 from the California Children and Families Commission (Proposition 10). These funds are used to provide services to consumers from birth to age five. The Governor's Budget proposes to continue this funding in 2011-12, resulting in a General Fund savings of $50 million.

Increase Accountability and Transparency. This proposal would set parameters on the use of state funds for administrative expenditures of regional centers and service providers, increase auditing requirements, increase disclosure requirements, and maximize recoveries from other responsible parties.

Increase Federal Funds. The DDS has been successful in maximizing available federal funds associated with the Medicaid Home and Community-Based Services Waiver, and recouping federal funding for certain services provided through Intermediate Care Facilities for persons with developmental disabilities. This proposal would focus on increasing federal funding by: (1) expanding the pending federal 1915(i) State Plan Amendment to include additional consumers and related expenditures consistent with federal health care reform; (2) maximizing use of federal "Money Follows the Person" funding for individuals placed out of institutions; and, (3) pursuing other enhanced federal funding opportunities. This proposal would, at a minimum, save $65 million General Fund in 2011-12.

Implement Statewide Service Standards. This proposal would establish statewide service standards that set parameters and promote consistency in the array of services available through the regional centers. The DDS, with input from stakeholders, will issue Purchase of Service (POS) Standards for services in all budget categories. In developing these standards, DDS will consider eligibility for the service, duration, frequency and efficacy of the service, qualification of service providers, service rates, and parental and consumer responsibilities. The DDS will also consider the impact of the standards, coupled with prior reductions in the service area, on consumers, families and providers. Standards will vary by service category. Service standards will be developed to allow for limited exceptions to ensure the health and safety of consumers and avoid the risk of out-of-home placement or institutionalization. It is anticipated the implementation of additional service standards will result in significant General Fund savings necessary to achieve the overall required savings of $750 million.

The significant General Fund workload adjustments are as follows:

- Caseload Adjustment—A decrease of $69.4 million in 2010-11 and an increase of $61.5 million in 2011-12 as a result of revised population estimates.
- Expiration of Federal Stimulus Funds—An increase of $134.1 million due to the end of federal stimulus funding. The federal government assumed a greater share of program costs during the stimulus period of October 2008 through June 2011.

The significant General Fund policy issue adjustment is:

- Impacts from Other Departments—An increase of $1.5 million in 2010-11, and an increase of $54 million in 2011-12, as a result of establishing mandatory co-payments for all health-related visits, limiting physician and clinic visits, eliminating the optional Adult Day Health Care benefit, and reducing the Supplemental Security Income/State Supplementary Payment grants for individuals to the federal minimum.

Department of Mental Health

The Department of Mental Health (DMH) ensures that a continuum of care exists throughout the state for children and adults who are mentally ill by providing oversight of community mental health programs and direct services through state mental hospitals. The Governor's Budget includes $4.5 billion ($1.3 billion General Fund) for 2011-12.

Community Services

To provide additional resources for county mental health services, voters passed the Mental Health Services Act (Proposition 63) in 2004. The intent of Proposition 63 was to reduce the long-term adverse impact of untreated mental illness by developing services or expanding existing services at the local level. To fund these resources, Proposition 63 imposed a one-percent surcharge on personal income over $1 million. Proposition 63 estimated that revenue generated by the increased tax over the first four years would be $2.4 billion. Actual revenue for that four-year period was $4.7 billion. Currently, Proposition 63 has a $2 billion balance.

Use Proposition 63 Fund Balances to Fund Community Services. Most direct mental health services in California are provided through county mental health systems. The DMH allocates funds and provides oversight for a number of programs including the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, the mental health managed care program, and mandated mental health services for special education students.

The EPSDT program is an entitlement for children and adults under age 21. The program provides services to approximately 230,000 Medi-Cal-eligible children and young adults to test for and correct or ameliorate mental illnesses. In recent years, caseload, services provided, and total expenditures for the mental health portion of the EPSDT benefit have grown significantly due to a combination of changes in demographics, demand for services, market prices for services, policy, and litigation. The program is currently funded through a combination of state funds and federal reimbursements, as well as county funding for the costs above a previously established baseline. The Governor's Budget includes $1.4 billion ($579 million General Fund) for EPSDT.

Mental health managed care (MHMC) is a locally based managed care system for Medi-Cal mental health services. MHMC provides psychiatric inpatient hospital services and outpatient treatment services through county mental health plans. County mental health plans authorize payment for Medi-Cal specialty mental health services and ensure Medicaid matching funds for these services. MHMC is funded with a combination of state funds and federal reimbursements. The Budget includes $367.1 million ($183.6 million General Fund) for MHMC.

The mandated mental health services for special education students, including students placed in out-of-state residential facilities, are commonly referred to as AB 3632 services. These services have been funded with a combination of state funds, including funding from the Medi-Cal program, federal special education funds, General Fund, and county realignment funding. These services are required by federal special education law. State law shifts responsibility for providing these services from schools to counties. Claims for costs incurred are submitted to the state for reimbursement. The Budget includes $98.6 million General Fund for prior year costs incurred by counties.

Under this proposal, the EPSDT, mental health managed care, and AB 3632 services would be funded with Proposition 63 funds in 2011-12, resulting in a General Fund savings of $861.2 million. Commencing in 2012-13, the Proposition 63 funds would be replaced with dedicated revenue. These revenues would be used to fund the cost of community mental health programs as these programs are realigned to counties.

The significant General Fund workload adjustments are as follows:

- Expiration of Federal Stimulus Funds—An increase of $67.1 million due to the end of federal stimulus funding. The federal government assumed a greater share of program costs during the stimulus period of October 2008 through June 2011.
- EPSDT Program Adjustment—An increase of $95.9 million in 2011-12 as a result of an increase in the number of eligible Medi-Cal clients.
- MHMC Program Adjustment—An increase of $33.2 million in 2011-12 as a result of an increase in the number of eligible Medi-Cal clients.

Long-Term Care Services

State hospitals operated by DMH provide long-term care and services to the mentally ill. The General Fund supports judicially committed, Penal Code, and Sexually Violent Predator patients, while counties fund civil commitments. The Governor's Budget includes $1.2 billion General Fund and 11,716.3 positions for 2011-12. The patient population is projected to reach a total of 6,324 in 2011-12.

The significant General Fund workload adjustments are as follows:

- Workforce Cap Adjustment—A decrease of $55.3 million in 2010-11 and 2011-12.
- Personnel Costs—A decrease of $56.8 million in 2010-11 as a result of negotiated contracts and the continuation of furloughs for employees without contracts and a decrease of $20.8 million in 2011-12 as a result of negotiated contracts.
- State Hospital Population Adjustment—An increase of $7.5 million in 2011-12 as a result of the accelerated admissions plan for the Coleman court-ordered 64-bed expansion at Vacaville Psychiatric Program.

The significant General Fund policy issue adjustment is:

- Billable Legal Services Conversion—An increase of $3.4 million in 2011-12 as a result of the transfer of responsibility for legal services funding to the DMH from the Department of Justice (DOJ). Of this amount, an increase of $2.5 million is a result of the additional legal services workload related to minor hearings and tort work historically performed by the DOJ on behalf of DMH.

Department of Social Services

The Department of Social Services (DSS) provides aid, service, and protection to children and adults in need of assistance. DSS programs are aimed at promoting the well-being of children, strengthening families, and helping adults and parents achieve their potential for economic self-sufficiency.

The Governor's Budget includes $19 billion ($8.7 billion General Fund) for the DSS, a decrease of $110.7 million General Fund from the revised 2010-11 budget, but an increase of $445.8 million General Fund over the Budget Act of 2010.

California Work Opportunity and Responsibility to Kids

The CalWORKs program is California's version of the federal Temporary Assistance for Needy Families (TANF) program. CalWORKs is California's largest cash aid program for children and families and is designed to provide temporary assistance to meet basic needs such as shelter, food, and clothing, in times of crisis. While providing time-limited assistance, the program promotes self-sufficiency through work requirements and encouraging personal accountability. The program recognizes the different needs of each county and affords them program design and funding flexibility to ensure successful implementation for families at the local level.

Total CalWORKs expenditures of $6.5 billion (state, local, and federal funds) are proposed for 2011-12, including TANF Block Grant and maintenance-of-effort (MOE) countable expenditures. The amount budgeted includes $4.5 billion for CalWORKs program expenditures within the DSS budget, $69.4 million in county expenditures, and $1.9 billion in other programs. Other programs include expenditures for Cal Grants ($946.8 million), State Department of Education child care ($413.9 million), Child Welfare Services ($235.4 million), DDS programs ($77.2 million), Foster Care ($72.9 million), the Statewide Automated Welfare System ($55.9 million), Title IV-E Waiver ($45.6 million), California Community Colleges child care and education services ($26.7 million), Department of Child Support Services disregard payments ($15.1 million), California Food Assistance Program ($10.3 million), and State Supplementary Payment ($1.9 million).

After many consecutive years of decline, the CalWORKs program has experienced significant caseload growth in recent years—a result of the economic downturn. Absent the program changes described below, the average monthly caseload in this program is estimated to be 580,000 families in 2011-12, a 0.5-percent decrease from the 2010-11 projection. The proposed changes to CalWORKs are estimated to reduce the 2011-12 caseload projection to 458,000 families, a 21.3-percent decrease from the 2010-11 estimate.

CalWORKs differs from welfare programs in other states in three significant areas: (1) California is one of eight states that provides a safety net program for children after the adult(s) reach(es) the 60-month time limit; (2) California's grant level is fourth highest in the nation, and ranks second highest of the ten largest states; and, (3) California has one of the most generous income disregards (the amount of income that is not counted for purposes of determining a family's grant amount) in the nation.

Establish Time Limit of 48 Months. California currently provides monthly cash benefits to eligible families for up to 60 months and provides benefits to children until the age of 18 years. This proposal would eliminate monthly benefits for families that have received CalWORKs aid for 48 months or more, with certain exceptions. Child-only benefits would continue beyond the 48-month time limit for families fully meeting work participation requirements. Additionally, child-only benefits would continue beyond the 48-month time limit for families with unaided adult recipients of SSI/SSP and non-needy caretaker relatives as, absent CalWORKs aid, many of the children in these families would receive other benefits at a higher cost to the state. Establishing a firm 48-month time limit in California would save $698.1 million in 2011-12.

Many states have established shorter time limits. As of 2009, nine states (including three of the ten largest states) have policies that terminate benefits for families prior to the maximum 60 months allowed by the federal government. California would still provide child-only benefits to cases that have reached the 48-month time limit to the extent these families meet federal work participation requirements, thus providing a strong incentive for these families to continue working with the goal of attaining self-sufficiency. This proposal assumes enacting state legislation by March 1 and implementation on July 1, 2011.

Reduce CalWORKs Grants. CalWORKs grant levels are currently fourth highest in the nation and second highest among the ten most populous states. This proposal would reduce the maximum monthly grant for a family of three from $694 to $604 (a 13-percent reduction), effective June 1, 2011, for savings of $13.9 million in 2010-11 and $405 million in 2011-12. Even with this reduction, California's grant levels would be the ninth highest of all 50 states and remain second highest of the ten most populous states. While a grant reduction would reduce the monthly income families receive from

CalWORKs, their CalFresh (formerly Food Stamp) benefit levels would increase, thereby partially offsetting the reduction to families' total resources. This proposal assumes enacting state legislation by March 1 and implementation on June 1, 2011.

Maintain the 2010-11 County Single Allocation Reduction. The single allocation to counties provides funding for CalWORKs employment services, child care, and county administration. The single allocation methodology provides counties with the flexibility to prioritize these funds to ensure desired programmatic outcomes at the local level. This proposal would maintain the reduction to the CalWORKs single allocation funding levels included in the 2009 and 2010 Budget Acts for savings of $376.9 million in 2011-12. Because this reduction is being continued as an unallocated reduction, counties will need to re-prioritize the use of single allocation funds to serve clients in the most efficient and effective manner. This proposal assumes implementation on July 1, 2011.

The CalWORKs program changes described above will generate total savings of nearly $1.5 billion (TANF and General Fund) in 2011-12. Of this amount, $533.1 million General Fund savings is achieved within the DSS budget. The remaining amount, $946.8 million, reflects TANF savings that will be transferred to the California Student Aid Commission to offset a like amount of General Fund costs for Cal Grants.

An additional $34 million General Fund savings in CalWORKs will be achieved in 2011-12 from a proposal to reduce the age eligibility for subsidized child care services. (See K-12 Education section for additional detail.)

Supplemental Security Income/State Supplementary Payment

The federal Supplemental Security Income (SSI) program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. In California, the SSI payment is augmented with a State Supplementary Payment (SSP) grant. These cash grants assist recipients with basic needs and living expenses. The federal Social Security Administration administers the SSI/SSP program, making eligibility determinations and grant computations and issuing combined monthly checks to recipients. California's SSI/SSP caseload consists of 28 percent aged, 2 percent blind, and 70 percent disabled persons.

The Governor's Budget proposes $2.7 billion General Fund for the SSI/SSP program in 2011-12. This represents a 3.8-percent decrease from the revised 2010-11 budget. The caseload in this program is estimated to be 1.3 million recipients in 2011-12, a 0.8-percent increase over the 2010-11 projected level.

Reduce SSI/SSP Grants for Individuals to the Federal Minimum. This proposal would reduce monthly SSP grants for individuals to the federally required minimum payment standard. Under this proposal, the maximum monthly SSI/SSP cash grant for individuals would be reduced by $15 per month (from $845 to $830), beginning June 1, 2011. SSP grants for couples were previously reduced to the federal minimum in November 2009. Even with the proposed reduction, California's SSI/SSP payments would remain the second highest in the nation.

The proposal will generate estimated General Fund savings of $14.7 million in 2010-11 and $177.3 million in 2011-12. These savings are net of increased General Fund costs assumed in the DDS budget. This proposal assumes enacting state legislation by March 1 and implementation on June 1, 2011.

In-Home Supportive Services

The In-Home Supportive Services (IHSS) program provides support services, such as house cleaning, transportation, personal care services, and respite care to eligible low-income aged, blind, and disabled persons. These services are provided in an effort to allow individuals to remain safely in their homes and prevent institutionalization.

The Governor's Budget proposes $1.1 billion General Fund for the IHSS program in 2011-12. Absent the program changes described below, the average monthly caseload in this program is estimated to be 456,400 recipients in 2011-12, a 3.4-percent increase over the 2010-11 projected level.

IHSS services in general exceed similar services provided in other states and serve a much wider population. Major cost drivers for IHSS include caseload, cost per hour, and hours per case. Over the last ten years, caseload has increased from 249,000 in 2000-01 to 429,000 recipients in 2009-10. This accounts for more than 50 percent of the increase in total costs over this period. Also over this period, state law triggered a series of increases in the hourly amount up to which the state participates in IHSS worker wages and health benefits. This accounts for more than 35 percent of the increase in total costs. Hours per case account for approximately 10 percent of the increase in costs from 2000-01 to 2009-10.

To contain costs, several reductions are proposed for 2011-12. Each IHSS reduction proposal assumes enacting state legislation by March 1 and implementation of each proposal July 1, 2011. Each reduction is described in detail below.

Across-the-Board Reduction to Service Hours. This proposal would implement an 8.4-percent reduction to assessed hours for all IHSS recipients for General Fund savings of $127.5 million in 2011-12. This proposal, combined with the 3.6-percent reduction enacted in 2010-11, would bring the total across-the-board reduction in assessed hours for IHSS recipients to 12 percent. Under this proposal, qualified recipients at risk of out-of-home care placement because of the reduction could apply for supplemental hours. As such, it is estimated that approximately 21,000 recipients will ultimately receive full restoration of their assessed hours, and this impact is reflected in the savings assumed in the budget.

Eliminate Domestic and Related Services for Certain Recipients. This proposal would eliminate domestic and related services (which include housework, shopping for food, meal preparation and cleanup, and laundry) for consumers living with their provider. Approximately 48 percent of IHSS providers live with the consumers for whom they care. In addition, this proposal would eliminate domestic and related service hours for recipients under eighteen years of age who live with a parent who is able and available to provide the domestic and related services.

Currently, when an IHSS applicant/recipient resides in a shared living arrangement and his/her need for any domestic or related service is met in common with other household members, the authorized hours are pro-rated by county social workers based on the number of household members. Under this proposal, IHSS applicants/recipients living in any type of shared living arrangement would not be eligible for domestic and related services that can be met in common with other household members. IHSS applicants/recipients who have a need for domestic and/or related services that cannot be met in common due to a medically verified condition of other members of the shared living arrangement could be authorized hours for any of these services that meet the need assessment metrics. Similarly, when minor recipients are living with their parent(s), the need is being met in common; hence, the need for domestic and related service hours would no longer be allowed. Since minors would not be expected to be able to perform these services independently, the parent would be presumed available to perform these tasks unless the parent could provide medical verification of his/her inability to do so.

Eliminating domestic and related services for recipients in shared living arrangements and minor recipients living with an able and available parent is estimated to impact more than 300,000 recipients. The proposal will provide General Fund savings of $236.6 million in 2011-12.

Eliminate IHSS Services for Recipients Without Physician Certification. This proposal would require the provision of IHSS services to be conditioned upon a physician's written certification that personal care services are necessary to prevent out-of-home care. Under current law, upon Medicaid eligibility determination, IHSS applicants are required to be assessed by an authorized county social worker to determine the types of services needed and the number of hours required for each service category. Current IHSS recipients must also be reassessed by county social workers every 12 months (18 months if certain exemption criteria are met). Lacking in the current assessment/reassessment process is a medical evaluation, which would provide an increased level of certainty that IHSS services are being provided to those most at-risk of institutionalization. This proposal would require a medical level of review for all IHSS applicants/recipients to ensure services are needed to avert out-of-home placement.

Eliminating IHSS services for recipients without physician certification would result in the loss of services for approximately 43,000 recipients, providing General Fund savings of $120.5 million in 2011-12.

Eliminate State Funding for IHSS Advisory Committees. This proposal would eliminate the mandate for counties to establish advisory committees, for General Fund savings of $1.6 million in 2011-12. Chapter 90, Statutes of 1999 mandated that counties act as or establish an employer-of-record for IHSS providers and establish advisory committees for IHSS purposes. Advisory committees submit recommendations to their respective county boards of supervisors on the preferred mode of IHSS service to be utilized in their counties. Although this proposal would eliminate state funding for advisory committees, counties would have the option to continue advisory committees at their own expense. Those counties that choose to do so would be eligible for matching federal funds.

Child Welfare Services

The child welfare system in California provides a continuum of services to children who are either at risk of or have suffered abuse and neglect. Children's programs include: Child Welfare Services, Child Abuse Prevention, Foster Care, Adoption Assistance, and Kinship Guardianship placements. Program success is measured in terms of improving the safety, permanence, and well-being of children and families served. The Governor's Budget includes $4.2 billion ($1.7 billion General Fund) to provide assistance payments and services to children and families under these programs, an increase of $23.2 million General Fund, or 1.4 percent, over the revised 2010-11 budget. The Budget proposes to realign these county-administered programs (see the realignment chapter for additional details).

Reduce Transitional Housing Program–Plus. The Governor's Budget includes a reduction of $19 million General Fund beginning in 2011-12. This reduction reflects the cost of Transitional Housing Program-Plus (THP-Plus) services for 18- and 19-year olds. This reduction is proposed in light of the passage of Chapter 559, Statutes of 2010 (AB 12), which expands foster care to age 19 in 2011-12 and allows for the placement of non-minor foster youth in a transitional housing program similar to the THP-Plus model. This proposal intends to save General Fund, while allowing those 18- and 19-year old youth wishing to participate in a foster youth transitional housing program to move to the AB 12-funded program, where the state is able to draw down federal Title IV-E reimbursement for the cost of providing services. This proposal assumes implementation on July 1, 2011.

The significant General Fund workload adjustments are as follows:

- Unachievable Federal Stimulus Funds—An increase of $395.4 million General Fund in 2010-11 due to the federal government not extending federal stimulus funding for CalWORKs beyond September 30, 2010, as was assumed in the 2010 Budget Act.
- Expiration of Federal Stimulus Funds—An increase of $842.6 million in 2011-12 due to the end of federal stimulus funding for the CalWORKs, IHSS, Foster Care, and Adoption Assistance programs.
- One-Time Savings—An increase of $435.9 million in 2011-12 reflecting restoration of the one-time savings included in the 2010 Budget Act from removing state funding for the Seriously Emotionally Disturbed Foster Care population ($70 million) and receiving an advance of funding from the federal government for CalWORKs ($365.9 million).
- Statutory-Driven Caseload and Payments—An increase of $417 million General Fund in 2011-12 primarily due to increased caseload and payment projections in the CalWORKs, IHSS, and CalFresh programs, partially offset by a decreased cost projection for the SSI/SSP program.

A summary of the significant General Fund solutions are as follows:

- CalWORKs Cost Containment—A decrease of $13.9 million General Fund in 2010-11 and $533.1 million General Fund in 2011-12 as a result of the following

CalWORKs proposals: (1) establishing a 48-month time limit; (2) reducing CalWORKs grants; and, (3) maintaining the 2010-11 reduction in the single allocation provided to counties. Additional savings of $946.8 million General Fund are achieved in the California Student Aid Commission budget as a result of these proposals.

- Reduce SSI/SSP Grants — A decrease of $14.7 million General Fund in 2010-11 and $177.3 million General Fund in 2011-12 by reducing monthly SSI/SSP grants for individuals to the federal minimum.
- IHSS Cost Containment — A decrease of $486.1 million General Fund in 2011-12 as a result of the following IHSS proposals: (1) applying an across-the-board reduction to service hours; (2) eliminating domestic and related services for certain recipients; (3) eliminating services for recipients without physician certification; and, (4) eliminating state funding for IHSS advisory committees.
- Reduce Funding for the Transitional Housing Program — A decrease of $19 million General Fund in 2011-12 by reducing funding for Transitional Housing Program-Plus services. As indicated above, the intent of the proposal is to save General Fund, while allowing those 18- and 19-year old youth wishing to participate in a transitional housing program to move to the AB12-funded program for which the state is able to draw down federal funds.

Department of Child Support Services

The Department of Child Support Services (DCSS) is designated as the single state agency responsible for administering the statewide child support system. The primary purpose of the DCSS is to secure, collect, and distribute child, spousal, and medical support on behalf of custodial parents and children.

The Governor's Budget includes $1 billion ($328.3 million General Fund) for the DCSS, a decrease of $6.9 million General Fund from the revised 2010-11 budget and an increase of $18.1 million General Fund from the 2010 Budget Act.

Child Support Collections

The child support program establishes and enforces court orders for child, spousal, and medical support from absent parents on behalf of dependent children and their caretakers. For display purposes, the Governor's Budget reflects the total collections received, including payments to families and collections made in California on behalf of other states. The General Fund share of assistance collections is included in statewide revenue projections. The General Fund portion of child support collections is estimated to be $212.2 million in 2010-11 and $246.7 million in 2011-12. The increased General Fund collections in 2011-12 primarily reflect the following proposal:

Suspend County Share of Collections. The Governor's Budget proposes to suspend the county share of child support collections in 2011-12. The county share of collections is estimated to be $24.4 million in 2011-12. Under this proposal, the entire non-federal portion of child support collections would benefit the General Fund. This would not reduce the revenue stabilization funding of $18.7 million ($6.4 million General Fund) counties receive to maintain caseworker staffing levels in order to stabilize child support collections.

The significant General Fund workload adjustments are as follows:

- Unachievable Federal Stimulus—An increase of $18.9 million General Fund in 2010-11 as a result of the federal government not allowing child support incentive funds to be used to match federal funds beyond September 30, 2010, as was assumed in the 2010 Budget Act.
- Expiration of Federal Stimulus—An increase of $25.2 million General Fund in 2011-12. The federal stimulus enabled the DCSS to use incentive funds in lieu of General Fund to match federal funds.
- Automation System—A decrease of $6.6 million General Fund in 2011-12 to reflect reduced costs for the California Child Support Automation System as well as a transfer of support activities from contracted vendor services to state staff.

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